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## 2015 REPORT

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### Abuse, Neglect, and Mistreatment at Montana Developmental Center

January 2015

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## DISABILITY RIGHTS MONTANA RECOMMENDS CLOSURE OF MONTANA DEVELOPMENTAL CENTER AND INVESTMENT IN COMMUNITY SERVICES

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FOR IMMEDIATE RELEASE  
January 23, 2015

DISABILITY RIGHTS MONTANA released a report today with significant details of numerous case stories of abuse and neglect at the Montana Developmental Center. Investigations conducted by the Department of Justice over the course of the past year reveal that twenty-seven staff members, including the Director of Quality Assurance and Superintendent, have been involved in the case stories. Some of the cases involve serious injuries, rape, and felony assault.

DRM has monitored MDC for more than twenty years, and cites a climate and culture at MDC that perpetuates and tolerates abuse. The cases cited in the report document slapping, grabbing, squeezing, pulling residents by the ankles, throwing them hard to the ground, kneeling on them, grabbing them by their clothing, and other efforts to control residents. Abuse and neglect has been substantiated against 27 employees this past year.

Residents cannot be reassured they are safe when 20 of the 27 staff who engaged in the abusive and neglectful behavior return to work. MDC Administration is not taking action to keep residents safe.

MDC is not able to hire and maintain adequately trained staff. The facility is consistently understaffed which leads to limited treatment and unfavorable conditions. Today there are at least 22 job vacancies to include direct care and professional staff.

The average population in 2014 at Montana Developmental Center was 50 residents. The cost to operate MDC is in excess of \$15M per year.

DRM is asking the 2015 Legislature to issue a directive to close MDC, and treat our fellow citizens with dignity and respect by providing appropriate community services. "A transition plan, developed by stakeholders that closes MDC and shifts resources into community services can be done. Montana needs leadership to make it happen," said Bernadette Franks-Ongoy, the executive director of Disability Rights Montana. "The Legislature can be that leader."

For a full copy of the report and recommendations, please go to our website at [www.disabilityrightsmt.org](http://www.disabilityrightsmt.org).

January 22, 2015

Disability Rights Montana, the state protection and advocacy system for Montanans with disabilities has monitored the Montana Developmental Center (MDC) for over 20 years.

Disability Rights Montana strongly recommends that the 2015 Legislature act with a sense of urgency and direct the Department of Public Health and Human Services to develop a transition plan that moves all 50 residents at MDC into appropriate community services and closes the facility in Boulder.

This report provides sufficient evidence to demonstrate that DPHHS is not able to carry out the mission of the Montana Developmental Center which is “. . . to provide an environment for building healthy, effective, and fulfilling lives.” This report details how approximately 15 million of tax dollars are used to support a facility that tolerates and perpetuates abuse, neglect and mistreatment of people with disabilities who are committed by the government for care and treatment.

The facts detailed in this report make it clear that the Montana Developmental Center cannot be transformed into a “Center for Excellence” and everyday this facility remains open, its residents are at risk of harm.

A transition plan, developed by a group of stakeholders that closes MDC and provides appropriate community services can be done. It has been done in 13 states.

Montana needs leadership to make it happen. Disability Rights Montana is asking the 2015 Legislature to be the leader and issue the directive to close MDC, treat our fellow citizens with dignity and respect by providing appropriate community services.

I want to thank the Department of Justice, Dana Toole, Catherine Scott, and Dawn Spencer for doing their jobs well and with integrity. Your work has shined a light and is providing transparency to some of the practices at MDC. I also want to thank DRM staff, Roberta Zenker, Beth Brenneman, Steve Heaverlo, and Laurie Danforth for writing and editing this report.

The residents at the Montana Developmental Center are entitled to be treated with dignity and respect. My hope is that this report will make a real difference in their lives.



Bernadette Franks-Ongoy  
Executive Director

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## INTRODUCTION

The Montana Developmental Center (“MDC”) in Boulder Montana is a residential facility operated by the State of Montana’s Department of Public Health and Human Services. MDC is composed of two distinct treatment areas. The largest is the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) which has a population of approximately 44 individuals and is federally certified. The other is the Assessment and Stabilization Unit (ASU) which is a secure (fenced and locked) 12 bed unit licensed by the State of Montana as an Intermediate Care Facility for Individuals with Disabilities ICF/ID).

Disability Rights Montana (“DRM”) has been monitoring abuse and neglect at MDC for more than 20 years. Throughout that time, MDC has consistently failed to fulfill its mission “. . . to provide an environment for building healthy, effective and fulfilling lives.” Since 2003, it has been the recipient of six immediate jeopardy findings from the Center for Medicaid Services (“CMS”), which were largely based upon deficiencies in its response to abuse and neglect of residents.

*MDC has consistently failed to fulfill its mission “. . . to provide an environment for building healthy, effective and fulfilling lives.”*

DRM succeeded through litigation in markedly downsizing the institution in 2005. Even though the institution served far fewer people, it continued to struggle with employing sufficient well-trained staff and failed to protect residents from abuse and neglect. The facility has continued to be the recipient of poor certification findings, and has been the defendant in tort claims for the mistreatment and abuse of residents.

In 2013, after a particularly damning report of MDC’s botched investigation of the rape of a female resident by a staff member, the Montana Legislature passed a new measure to establish independent investigation of alleged abuse, neglect, and mistreatment of residents. It established that the Montana Department of Justice (“DOJ”) would investigate claims instead of MDC staff. It also required that all reports be sent to DRM for its independent review.

MDC claimed that it would reform in the wake of the rape scandal. Its Administration promised to turn the institution into a “center for excellence,” and it hired a clinical director and updated and amended many of its policies regarding abuse, neglect, and mistreatment of residents.

*Even though MDC pledged to change, the reports DRM received demonstrate the inability of MDC to keep residents safe from staff and from one another.*

Even though MDC pledged to change, the reports DRM received demonstrate the inability of MDC to keep residents safe from staff and from one another. Further, the reports confirm there are deep and abiding defects in the climate and culture at the institution.

The following report includes case stories which DRM has collected since the 2013 change in state law. The stories include instances of staff abuse of residents and mistreatment of residents by other residents. These

instances reveal significant gaps in supervisory oversight by the MDC administration, in the selection and training of staff, the administration of the facility, and failure to adequately address these incidents once they have occurred.

DRM has observed and tried to influence change for years as MDC has tried and failed to be a safe institution for the habilitation and treatment of people with intellectual disabilities. The simple truth seems to be that MDC cannot be made safe.

## SHORT CONCLUSIONS

1. Montana Code Annotated § 53-20-163 (attached as Exhibit 1) has been a success as it has placed independent investigators at MDC and has provided far more information to DRM, an independent watchdog, of the abuse and neglect occurring in this institution.
2. Substantiated abuse and neglect at MDC results from cultural problems at the institution. In an effort to address its problems with an insufficient labor pool, MDC will often accept poorly suited individuals to employ, rationalize poor employee performance, and downplay the seriousness of abuse and neglect by addressing incidents with insufficient disciplinary and retraining attempts.
3. MDC is not able to hire and maintain adequately trained staff.
4. The physical layout of the facility buildings is inefficient and dangerous.
5. It is not possible to run a safe, effective ICF/IID and ICF/ID that function as a “center for excellence” in Boulder, Montana.



## **LEGAL FRAMEWORK**

### **Federal Law**

The majority of MDC is an ICF/IID. As an ICF/IID, MDC is subject to federal regulations in order to receive Medicaid funding for services.

Specifically, MDC must “ensure that clients are not subjected to physical, verbal sexual or psychological abuse or punishment.” 42 C.F.R. § 483.420(a)(5). To that end, a facility “is responsible to organize itself in such a manner that it proactively assures individuals are free from serious and immediate threat to their physical and psychological health and safety.”

When a surveyor cites a facility with violation of this regulation, “there is a high probability that abuse to individuals could occur at any time, or already has occurred and may well occur again, if the individuals are not effectively protected from the serious physical or psychological harm or injury, or if the threat is not removed.” CMS manual system, pub. 100-07 State Operations Provider Certification.

When such a violation is cited, it is called an “immediate jeopardy” finding and can result in the loss of Medicaid funding and closure of the institution.

### **State Law**

In 2013, the Montana Legislature enacted Montana Code Annotated § 53-20-163, requiring MDC to report each allegation of mistreatment, neglect, abuse or injury from an unknown source to the DOJ. The DOJ is required to thoroughly investigate the allegation, make findings, and generate a report within five days of the incident.

MDC is also required to report the details of each reported allegation to the Mental Health Board of Visitors and the state protection and advocacy program for individuals with developmental disabilities, as authorized under 42 U.S.C. § 15043(a)(2), also known as the Protection & Advocacy System (P&A). In Montana, the P&A is Disability Rights Montana. Since the legislation took effect in October 2013, DRM has received a copy of each report of the investigation of all allegations of mistreatment, neglect, abuse, or injury from an unknown source at MDC.

This legislation has enabled DRM to fulfill its mandate under 42 U.S.C. § 15043(a)(2), which is to investigate allegations of abuse and neglect at institutions where individuals who experience developmental disabilities live. Prior to this legislation, DRM had to rely on word-of-mouth reports from residents, family members, and staff to learn of instances of abuse or neglect. As some potential witnesses feared reprisals, reports were often withheld or withdrawn. Prior to the law, getting accurate counts of the incidents of abuse and neglect at MDC was difficult if not impossible. Now, as long as each allegation of mistreatment, neglect, abuse, or injury from an unknown source is immediately reported by MDC to the DOJ, an accurate count is much more likely.

In carrying out its mandate, the DOJ relies upon MDC policy to define mistreatment, abuse, and neglect. MDC's policies defining these terms rely upon a combination of federal code and regulation, Montana code and administrative rule, and a lawsuit settlement.

MDC defines *abuse* as the infliction of physical or mental injury or the deprivation of food, shelter, clothing, or services necessary to maintain the physical or mental health of a client with a developmental disability, without lawful authority whether purposeful or due to carelessness, inattentiveness, or omission by the person causing harm. Abuse may be physical, verbal, psychological, or sexual.

MDC defines *mistreatment* as any of a number of elucidated practices in the policies that deviate from Individual Treatment Plans and accepted treatment practices and standards of care in the field of intellectual disabilities.

MDC defines *neglect* to mean the failure to provide services necessary to avoid physical or psychological harm. This includes failure to protect clients from harm caused by other clients.



## FACTS - CASE STORIES

Montana Code Annotated § 53-20-163 took effect in October 2013, the DOJ took approximately six months to hire an investigator and get its program up and running. The DOJ investigator filed her first MDC investigation report in April 2014.

Between October 2013 and April 2014, MDC conducted and filed its own investigative reports with the DOJ and provided DRM with copies. DRM has been able to track and review reports of mistreatment, neglect, abuse, or injury from an unknown source at MDC for the period of October 2013 through November 2014 for purposes of this report.

### A. Staff to Resident Physical Abuse - Case Stories (12 cases)

1. MDC substantiated physical abuse of Resident A on December 13, 2013, perpetrated by Staff # 101, by placing his knee on Resident A's arm while he was being restrained.
2. MDC substantiated physical abuse of Resident B on December 13, 2013, perpetrated by Staff # 102, by throwing him to the ground, breaking Resident B's clavicle.
3. MDC substantiated physical abuse, verbal abuse, psychological, and sexual abuse of Resident C on February 11, 2014, by Staff # 103, by "nut checking," a game whereby Staff # 103 would attempt to catch Resident C off guard by backhanding him in the genitals. The game also included on-going verbal interactions between Staff # 103 and Resident C consisting of graphic sexual content.
4. MDC substantiated physical abuse of Resident C on April 28, 2014, perpetrated by Staff # 104, who pushed Resident C.
5. DOJ substantiated physical abuse of Resident D on July 24, 2014, by Staff # 105, who slapped Resident D in the face.
6. DOJ substantiated physical abuse of Resident D on July 24, 2014, by Staff # 105 and # 106, who pulled Resident D off the couch by her ankles and dragged her down the hall to her bedroom.

7. DOJ substantiated physical abuse of Resident E on July 11, 2014, by Staff # 107, who grabbed the back of Resident E's neck and pushed him.
8. DOJ substantiated physical abuse of Resident F on July 11, 2014, by Staff # 107, who grabbed Resident F's neck, squeezed it, and brought him to his room.
9. DOJ substantiated physical abuse of Resident G on July 31, 2014, by Staff # 109. Resident G punched Staff # 109 in the side of his head when Staff # 109 stepped in between Resident G and another resident who were about to engage in a fight. Staff # 109 responded by grabbing Resident G's neck and taking him hard to the floor.
10. DOJ substantiated physical abuse of Resident H on September 27, 2014, by Staff # 110, who charged across the room unprovoked and choked Resident H, slamming his head into a door jamb causing a laceration that required five staples at the emergency room to close.
11. DOJ substantiated physical abuse, verbal abuse, and mistreatment of Resident H on November 3, 2014, by Staff # 111, who grabbed his shirt, swore at him, and verbally threatened him.
12. DOJ substantiated physical abuse of Resident I on November 6, 2014, by Staff # 112, who dragged Resident I out of another resident's room by her ankles.

**B. Staff Verbal Abuse, Mistreatment, and Neglect - Case Stories (12 cases)**

13. MDC substantiated verbal abuse of Resident J on October 20, 2013, by Staff # 113, who yelled and swore at Resident J.
14. MDC substantiated verbal abuse of Resident K on October 20, 2013, by Staff # 113, who yelled and swore at Resident K.
15. MDC substantiated neglect of Resident L on March 1, 2014, by Staff # 114, who left Resident L sleeping in a bed with a urine soiled blanket belonging to another resident.





A mechanical restraint chair is commonly used at MDC. Amnesty International among others have condemned the use of such chairs, especially in treatment settings because of the possibility of causing further trauma. They have been condemned for use in corrections settings as well given the possibility of death or injury due to asphyxiation.

16. MDC substantiated mistreatment of Resident I on April 14, 2014, by Staff # 115, by putting her in a mechanical restraint chair and locking her in her bedroom.
17. MDC substantiated mistreatment of Resident I on April 14, 2014, by Staff # 116, by telling her that she was stupid in front of other residents.
18. DOJ substantiated mistreatment and neglect of Resident C on April 28, 2014, by Staff # 104, who pushed Resident C.
19. DOJ substantiated neglect of Resident J on July 12, 2014, by Gene Haire, Perry Jones, Larry LeRoux, Staff # 116, and Staff # 117, by leaving him in his tent outside, unsupervised all night while the rest of the group went back to the unit.<sup>1</sup>
20. DOJ substantiated verbal abuse of Resident H on August 1, 2014, by Staff #118, who called Resident H a "prick."
21. DOJ substantiated neglect of Resident M on August 22, 2014, by Staff # 119 and Staff # 120, who left Resident M and another resident unattended.
22. DOJ substantiated neglect of Resident M on September 4, 2014, by MDC staff when Resident M walked out of the building and was discovered at the grocery store in downtown Boulder, Montana.

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<sup>1</sup>Facility administrators are entitled to less privacy than line staff, if any at all, since they are public officials performing their public duties.

23. DOJ substantiated neglect of Resident M on September 17, 2014, by MDC staff when Resident M walked out of the building and was discovered on Main Street in downtown Boulder, Montana.
24. DOJ substantiated neglect of Resident N on November 3, 2014, by Staff # 121, Staff # 122, Staff # 123, and Perry Jones, surrounding the circumstances which resulted in the rape of Resident N by another resident. It was not until the victim was examined by a staff nurse (two hours after the event) that her allegation was taken seriously and she was taken to the hospital.

### **C. Immediate Jeopardy**

MDC's inability to investigate and prevent abuse and neglect of residents has been consistent since 2003. CMS found that MDC was posing an immediate jeopardy to the health and safety its residents in 2003, 2005, 2008, 2009, 2010, and 2011. Here are CMS' findings:

2003: The facility was "[f]ailing to ensure the most fundamental protections by failing to provide necessary services and supports to avoid physical harm during the application of restraint and by failing to further protect clients from harm during the investigation of abuse."

2005: The facility was not in compliance with federal, state, and local sanitation laws, and failed to thoroughly investigate allegations of abuse, and failed to report the results of investigations of resident-to-resident abuse.

2008: Staff at the facility threatened a resident with an injection for their own convenience, used force without justification, failed to recognize and report abuse, and failed to conclude abuse in the face of factual evidence and take appropriate action.

2009: The facility failed to ensure protection from harm when it allowed an abusive staff member to return to a unit to retrieve her belongings.

2010: Following the rape of a resident by a staff member, the surveyors found the facility failed to adequately supervise employees, collect physical evidence in a timely manner, utilize objective facts to



thoroughly investigate the allegation in a timely fashion, failed to include a review of system failures including procedure review, staff failures, environmental supervision review, and procedures to ensure the safety of residents.

2011: The Centers for Medicare & Medicaid Services found that the facility's Human Resource's Department failed to protect the residents from staff errors.

MDC has also been a defendant in tort claims cases including one for the mistreatment of a resident brought in the wake of a staff rape of a female resident. MDC paid the victim and her family \$350,000 in 2013 to settle the case.<sup>2</sup>

## **Challenges at MDC**

### **A. Difficulty Hiring and Maintaining an Adequately Trained Staff**

Boulder, Montana, is remote and has a small population from which to draw a labor force. Many employees and health care professionals have to commute from Butte or Helena, requiring MDC to compete with local employers for adequate staff.

This was noted in a recent report by a fiscal analyst for the Interim Legislative Finance Committee on December 2, 2014. Based upon interviews with MDC Administrators, the analyst stated:

The facility has difficulty hiring and maintaining an adequately trained staff. This has led to high turnover, training costs and unmanned shifts. Reasons for this situation may include low wages, a difficult clientele, shift work, *the environment at MDC, and lack of a readily available work force.* (Emphasis added). (Attached as Exhibit 2, p. 2).

The report goes on to identify union practices as a significant factor that further complicates the provision of adequate staff in certain areas and at certain times at MDC:

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<sup>2</sup> See also, *Baker v. Alexander, et al*, First Judicial District, Lewis & Clark County No. CDV - 2002-215.

In addition, the workplace is largely unionized and job bidding based on seniority typically results in unfavorable conditions for facility staffing and scheduling. The result of the job bidding process is that, in many occasions, the newest personnel are subject to shift work at the highest secure areas with the most difficult clients during periods where minimal staff and management are present. *This has created opportunities with potential unfavorable outcomes.* (Emphasis added).

The facility Superintendent, Gene Haire (hereinafter “Superintendent”), admitted at the Legislative Finance Committee hearing on December 2, 2014, that rape and abuse were “unfavorable outcomes.”

This was demonstrably true with the neglect and abuse which occurred in the most serious cases described above, the rape of Resident N, and the serious assault of Resident H. In the rape case, the staff who left the residents unattended was on his first day working in the units, had not been informed of his work assignment, and was working an overtime shift.

Finally, the MDC Administration told the fiscal analyst that even with 250 staff at the facility, they needed 24 additional full time employees (“FTE”). At the time of the drafting of this report, MDC has 22 open job positions.<sup>3</sup> Together, MDC is down 48 staff from its optimum, or roughly one-sixth of its entire staff.

## **B. Layout of Facility**



Over the years, the number of individuals served by MDC has been greatly reduced. As this has occurred, buildings have been shuttered. The Administration continues to use cottages for residents which are situated apart from the main administration building. This has made it difficult to keep residents safe given that it requires a large number of staff.

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<sup>3</sup>These numbers remain consistent through January 14, 2015.



The layout requiring additional staff was also identified by the MDC Administration, as reported by the legislative fiscal analyst in his December 2, 2014, report. ["Due to spacing and set up of the facility (8 separate buildings located on approximately 1/4 mile of square area) there is a high requirement for FTE for optimum client supervision."] (Exhibit 2, p. 2).



Assessment and Stabilization Unit (ASU)

To adequately provide for resident safety given MDC's staffing patterns, substantial remodeling or rebuilding would need to occur.

### C. Remote Location of Facility

In 2007, largely in response to CMS immediate jeopardy findings, the State Developmental Disabilities Program requested a study of MDC, which was conducted by the nationally renowned Pennhurst Group. It identified the remote nature of the facility as a substantial problem:

MDC is exemplary of a 'smaller' ICF/MR. 'Economies of scale' afforded larger facilities elude those with smaller populations. Geography must also be seriously considered . . . Boulder, Montana requires more 'on site' resources than that of a less rural, more robust, densely populated, setting. Resources, employees and contractors must travel greater distances, for greater costs, than [in] other more densely populated settings.<sup>4</sup>



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<sup>4</sup>Study of MDC by the Pennhurst Group, 2007, at p. 2.



## SOME STATISTICS

There have been an average of approximately 50 residents at MDC over the course of the reporting period of October 2013 until November of 2014. Fifteen of those residents appear in the case stories above, some of them more than once. Hence, nearly one third of the residents have been mistreated, abused, or neglected by the staff at MDC during the last year. These staff have included direct care staff, supervisors, the Director of Quality Assurance, Perry Jones (hereinafter "Director of Quality Assurance"), and the Superintendent.

There have been 12 assaults perpetrated by staff against residents at MDC for an average of one assault per month during the reporting period.

Mary Dalton, Medicaid & Health Services Branch Manager, Montana Department of Public Health and Human Services ("DPHHS"), testified at a December 2, 2014, Legislative Finance Committee hearing that these numbers were an improvement and that MDC had made "great strides to improve over the last three years."

DRM cannot independently verify any such improvement because prior to the 2013 adoption of Montana Code Annotated, § 53-20-163, MDC was not subject to a reporting requirement beyond DPHHS. DRM has no prior data to which to compare the current data and do not know whether one staff assault of a resident per month is an improvement or not.

Many of the case stories involve multiple staff. In all, 27 staff members perpetrated mistreatment, abuse, or neglect against the residents of MDC in the cases contained in this report. As of November 6, 2014, 20 remain employed and only seven no longer work at this institution.<sup>5</sup> When asked at the December 2, 2014, hearing about termination of employees who abuse residents, the facility Superintendent testified that "[he didn't] have the numbers on how the cases break out." He also testified that there have been no allegations of any kind of sexual abuse of residents by staff. This was an error as in Case Story 3 above, the DOJ substantiated sexual abuse by staff.

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<sup>5</sup> Other staff have since left employment at MDC for reasons unknown at the time of publication of this report.

Finally, approximately one-half of the resident population of MDC is on the Port list, meaning that they have been deemed ready by MDC to be served in the community. MDC's weekly porting list of the residents that are referred to community placement, averaged 26 residents per week for community placement. In other words half of the population at MDC for over a year have been eligible to be served in a less restrictive environment, waiting for community services. Eighteen residents on the December 6, 2013, port list (attached as Exhibit 3) are still on the January 2015 port list (attached as Exhibit 4). They remain in a far more restrictive environment than necessary or appropriate.

## ANALYSIS

The case stories reveal significant gaps in supervisory oversight. This results in neglect that has led to serious abuse of residents such as rape and felony assault ending in serious injury and hospitalization. Resource challenges, physical layout, and union job bidding and seniority "typically results in unfavorable conditions for facility staffing and scheduling" that leave untrained staff in the most difficult and vulnerable areas all contribute to the risks to residents and are barriers that mostly cannot be overcome.

Even a cursory comparison of the case stories above to the previous immediate jeopardy findings reveals that Mary Dalton's hopeful testimony before the December 2, 2014, Legislative Finance Committee hearing about improvement at MDC is not so. Clearly, MDC is not improving, and upon a proper complaint to the Certification Bureau should be found to be in immediate jeopardy yet again.

*Residents cannot be reassured they are safe from these kinds of assaults. When they see 20 of the 27 staff who engaged in the assaultive behavior returning to work, residents cannot be assured that the administration is taking any action to keep them safe.*

### A. Resident Safety

At MDC, there is a climate and culture that perpetuates abuse. DRM finds this in the types and frequency of abuse as well as in the lack of timely, professional follow-up to abuse. The same failures of protocol in 2014 were present at the facility in 2010 and years prior as demonstrated in the numerous case stories and immediate jeopardy findings above. The same failures to engage in swift and certain discipline of staff who abuse residents exist today.



The stories above demonstrate the absence of proper training in behavior management techniques. Staff have commonly resorted to painful, humiliating, and sometimes dangerous physical interventions. In the cases cited, staff have used slapping, grabbing residents by the neck and squeezing, pulling residents by the ankles, throwing residents hard to ground, pushing residents, kneeling on residents, grabbing residents by their clothing, to physically control residents. Given the frequency of these incidents over the last year, the absence of sufficient

*The failure of MDC staff and administrative personnel to respond immediately in the November 2014 incident is perhaps the clearest evidence that critical elements have not changed at MDC.*

staff training in de-escalation techniques to avoid or defuse potential physical confrontations should have been evident to MDC's administration. Yet these incidents continued.

Residents cannot be reassured they are safe from these kinds of assaults. When they see 20 of the 27 staff who engaged in abusive and neglectful behaviors returning to work, residents cannot be assured that the administration is taking any action to keep them safe. Although Richard Opper, the DPHHS Director, has publicly stated that "[t]he State of Montana will not tolerate the abuse and neglect of patients at MDC," the sad fact is that the State has tolerated it for years, and continues to do so even now.

## **B. Rape**

Many were shocked by the revelations of the November 2014 rape of a resident and the subsequent failures of the MDC administration to properly investigate the incident.<sup>6</sup> Given that a rape of a previous resident in 2010 brought about changes in the MDC administration, the hiring of a clinical director, and the change of many policies regarding abuse and neglect, it would be reasonable to expect any future rape allegation would be addressed immediately and effectively. The failure of MDC staff and administrative personnel to respond immediately in the November 2014 incident is perhaps the clearest evidence that critical elements have not changed at MDC.

The November 2014 rape is included above as Resident N. Resident N is small of stature. She would be easily overpowered by the perpetrator here, a man who is

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<sup>6</sup>November 25, 2014, Helena Independent Record.



almost a foot-and-a-half taller than she. On November 3, 2014, the two were left unsupervised at approximately 1:00 p.m. in the hallway during what is called “Treatment Mall” at MDC. The MDC Superintendent would later describe Treatment Mall as a school type setting where students walk between classes. The difference at MDC is that residents are always to be supervised or accompanied by staff, sometimes on a one-to-one basis.

Treatment Mall takes place physically in Building 8 which has two L-shaped halls running through it known as the “North Hall” and the “South Hall.” A staff “hall monitor” is located in each hallway. It is not clear that anyone had been assigned as the South Hall monitor where the rape took place. In any event, no staff were present. The DOJ report of the incident called it “[i]nsufficient or incompetent supervision,” and it should be noted that the lack of competence extends to the administration.

Two staff, one of whom had only been there a couple of weeks and was pulling a double shift to fill in for a vacancy, had both been assigned to the Quiet Room. Neither were aware that anyone had been assigned to the South Hall. The newer staff was supposed to work his first day in the units at 2:00 p.m. and was attending to a personal matter prior to that time. He had come in early to work a double shift and may have been distracted. He planned to proceed to Unit 4.

*The perfect storm of incompetence continued to brew.*

To make matters worse, once the male resident had the female resident locked in the bathroom and staff were made aware of it, no one had a key to gain entry to the bathroom to rescue her. The perfect storm of incompetence continued to brew. As the perpetrator ejaculated, having withdrawn from the victim, she saw her chance and took it. She quickly unlocked the door and left.

Even though witnesses reported hearing “kissing” sounds, no staff interviewed the female resident until she came forward two hours later (at 3:00 p.m.). MDC policy, developed in response to the 2010 rape at MDC, called for immediate contact with law enforcement when a sexual assault is reported. It also calls for securing the scene, staying with the victim until law enforcement arrives, and then accompanying the victim to the emergency room for a sexual assault examination by trained professionals (called “SANE;” no nurses at MDC have this training). The MDC Superintendent and Director of Quality Assurance helped formulate and write this policy. They have actual knowledge and a working awareness of its

contents, and had even instituted a check-off list for such cases on January 31, 2013. (Attached as Exhibit 5).

Here, however, they did not follow the policy. Shift Manager, Staff # 123, who was made aware immediately that the perpetrator and victim had been locked in the bathroom, instructed staff to interview the male resident with a nurse. Predictably, the male resident denied it. No one interviewed the female resident, or contacted law enforcement, as required, at this time.

At approximately 2:20 p.m., the Director of Quality Assurance began participating in interviews relating to this event, yet still no one contacted law enforcement, spoke with the victim, or secured the scene. In fact, the Director of Quality Assurance directed a nurse at MDC to conduct a medical exam in direct contravention of the MDC policy and proper law enforcement practices. An untrained nurse conducted a rape exam at MDC. Then MDC determined to take the female resident to the emergency room without contacting law enforcement, again a violation of MDC's own policy. Still, no one secured the scene.

A St. Peter's Hospital nurse finally contacted Jefferson County Law enforcement personnel at 5:32 p.m., more than four hours after the incident. MDC did so later by fax. In addition, Montana Code Annotated § 53-20-163 requires MDC to notify the DOJ *immediately* of each allegation of abuse. Here, the Superintendent, with knowledge of the allegations, spoke with the Bureau Chief responsible for investigating these allegations at 4:43 p.m., and did not report the allegation. In fact, MDC did not report the allegation to DOJ until 6:57 p.m., almost six hours after the incident.

*The DOJ report of the incident called it "[i]nsufficient or incompetent supervision," and it should be noted that the lack of competence extends to the administration.*

Shortly before MDC reported the incident to DOJ, the janitor cleaned the bathroom, because she was not asked to do anything differently. When later asked about why he didn't insist that MDC's policy be followed, the Superintendent exclaimed: "I didn't think of it, it never crossed my mind." The critical incident protocol that the Superintendent wrote, signed, and implemented never crossed his mind during the critical incident. The form that he created did not even occur to him at the very time of its intended use. This seems the very pinnacle of incompetence, a complete failure of management that would likely



result in termination in the private sector. It is the same kind of conduct that resulted in immediate jeopardy to the health and safety to residents in 2010. This sort of occurrence at MDC is the very kind of practice that perpetuates the climate and tolerance of unacceptable practices and allows a culture of mistreatment, abuse, and neglect to thrive.

### **C. Resource Challenges**

The fiscal analyst's December 2, 2014, report is the most recent source to identify the serious staffing issues at MDC. For example, the practice of job bidding identified by the December 2<sup>nd</sup> report, not surprisingly results in the most senior workers taking the more sought after shifts with the least experienced staff often supervising the most challenging residents.

The 2007 Pennhurst Report found that the most challenging residents who are housed in the ICF-DD experience little positive or active treatment either because the staff was unwilling or unable to provide it:

It should be stated that the individuals who reside at the locked (ICF-DD) unit do present challenging, dangerous behavior and these individuals do require effective, consistent supervision and intervention to keep individuals, staff, and community members safe. During observations at the locked unit, sufficient numbers of staff were present to supervise and intervene if behavioral emergencies emerged, but *there was little positive interaction between staff and consumers.*<sup>7</sup> (Emphasis added).

The result is a cause-effect relationship where, in the absence of proper training on how to engage residents, engagement is either non-existent or negative.

Case Story 10 above is an instructive case. In Case Story 10, the DOJ substantiated physical abuse of Resident H on September 27, 2014, by a staff member who charged across the room unprovoked and choked Resident H, slamming his head into a door jamb causing a laceration that required five staples at the emergency room. This event took place just before 10:00 p.m. Video of the interaction between the staff and residents reveals that there was not only very

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<sup>7</sup>Pennhurst Report, page 30



little in the way of positive interaction, but that the interaction was almost entirely negative, mostly driven by the actions of the staff.

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MONTANA FIFTH JUDICIAL DISTRICT COURT, JEFFERSON COUNTY  
STATE OF MONTANA, Case No. DC-2014-07  
Plaintiff, INFORMATION  
v. SHELTON MOFFETT, Defendant.

STATE OF MONTANA }  
County of Jefferson } ss.  
Matthew J. Johnson, Jefferson County Attorney, being first duly sworn, deposes and says his oath states that the above-named Defendant, SHELTON MOFFETT has committed within Jefferson County, Montana, the criminal offenses of:

COUNT 1: ABUSE OF A DISABLED PERSON, a felony, in violation of 17-3-423, MCA in that on or about September 27, 2014, at Boulder, within Jefferson County, Montana, the Defendant, SHELTON MOFFETT, purposely or knowingly abused a person with a developmental disability, having inflicted physical injury on E.W.M., a developmentally disabled person by shoving E.W.M. hard into a doorframe, causing a large laceration on his head requiring 5 staples to repair the wound.

Punishable under 17-3-423, MCA, by imprisonment not to exceed 10 years and a fine not to exceed \$10,000.00, or both.

A list of possible witnesses for the State of Montana, now known to the prosecution, is as follows:

None.

Matthew J. Johnson

In the video, the victim of the assault is shown in a relaxed standing posture, leaning against the door frame with his arms crossed. Meanwhile, a transcript of the incident reveals that the perpetrator is taunting the residents saying that “I can go home at night, and you will never get out of here.” The perpetrator was charged with felony Abuse of a Disabled Person. The incident, which occurred seven years after the Pennhurst report, is illustrative of its seemingly prophetic statements:

Is staff being trained appropriately? If there is one department and task at MDC which could utilize the ‘most needed improvement’ label, this would be it. It is believed that even mandated training and that accountability for same has waned.

Training is evidently seriously needed for direct support to understand active treatment, behavioral interventions and levels of expectation for competent interactions.

Is staff being supervised appropriately? It is very apparent that ‘supervision’ at MDC has evolved where considerable learning could benefit change. Levels of staff interaction, cancellation of treatment or training time, use of client choice as an excuse for not providing programs are all indicative of inappropriate or absence of supervision.<sup>8</sup>

It is readily apparent from the September 27, 2014, assault on Resident H that the Pennhurst statements were just as true in 2014 as they were in 2007. Either training is seriously waning, or supervision is absent, or both.

DRM takes no position on organized labor at state institutions, an issue raised by the fiscal analyst’s report as negatively affecting resident care. To the extent that

<sup>8</sup>Pennhurst Report page 8.

union practices negatively affect the safety of residents then it must be addressed and changed.

The MDC Administration believes that 24 additional FTE are required to operate the facility at optimum level. (Exhibit 2). This would be in addition to the 250 positions currently at MDC, 22 of which are currently unfilled. It appears that MDC believes that it could hire itself out of this problem, though the Governor's budget does not include the funding for these additional FTE.

DRM does not believe it is credible to argue that additional staff would solve the problems at MDC. Back in 2007, the Pennhurst Group found that 111 direct care staff<sup>9</sup> for a total resident population of 61 was a "generous number of staff,"<sup>10</sup> yet they experienced the same sort of problems experienced at the facility currently. The picture could not be clearer. By all measures, the congregate care model in Boulder, Montana, is failing.

#### **D. Pre-screening by MDC**

In the fall of 2014, both DRM and DOJ became aware that MDC was employing its own "pre-screening" process by which it deemed some allegations not worthy of reporting. DRM became aware that these allegations were not being reported through reports of incidents by residents and their relatives.

*He was found in a chair soaked in urine when his mother came to visit.*

In one such case, the staff at MDC had neglected a man for a month who had a herniated disc and a pulmonary embolism from sitting too long in one position. He was left in that position as staff stated that they thought he was "faking." He was found in a chair soaked in urine when his mother came to visit. DRM reported the neglect to both DOJ and MDC, although MDC had known of it and failed to report this incident to DOJ. Based on DRM's reporting, DOJ has initiated its investigation. This investigation is pending at the time of this report.

In another example, DRM learned from a parent that her son had been assaulted by another resident. MDC was aware of the event, but did not report it to DOJ for

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<sup>9</sup>111 direct support staff was the number reported by the fiscal analyst as of November 28, 2014, and only incidentally the number of direct support staff reported by the Pennhurst report of direct support in 2007.

<sup>10</sup>Pennhurst report, p. 6.

three days as an allegation of abuse, and only did after DRM reported it to MDC. The statute requires MDC to immediately report each allegation of abuse to DOJ. Once notified, DOJ substantiated abuse in this case.

In response to this revelation, a Deputy Attorney General issued a Memorandum to the bureau chief in charge of these investigations which analyzes MDC's pre-screening policy. (Attached as Exhibit 6). In it, the deputy states that "[e]ach allegation must be reported without delay to DOJ" as the statute does not permit MDC to pre-screen allegations.

*... the deputy states that "[e]ach allegation must be reported without delay to DOJ" as the statute does not permit MDC to pre-screen allegations.*

Due to the pre-screening by MDC of allegations of abuse, particularly between residents, it is difficult, if not impossible, to report the total number of incidents of abuse, neglect, or mistreatment that have occurred since October 2013. DRM is reasonably certain the cases included in this report are a fraction of instances which have really occurred.

## **E. OLMSTEAD**

The State of Montana must come into compliance with the rule in *Olmstead v. Zimmering*, 119 S. Ct. 2176 (1999), which holds that it is illegal discrimination under the ADA to keep people who experience disabilities in institutions when they do not need to be there. *Id.* at 2191.

For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

When assessing the full measure of resources currently expended at MDC (approximately \$15 million), it is more a question of appropriations to assure compliance with *Olmstead*.

There have been numerous lawsuits across the county over the past 15 years surrounding this issue to underscore this point. Many of these are initiated by the



United States Department of Justice or the individual state's Protection and Advocacy Systems for people who experience disability, such as DRM. Inasmuch as half the population at MDC fits the *Olmstead* rule, it would seem utterly prudent to, at a minimum, reduce the institutional appropriation by an amount sufficient to provide for community placement for these individuals, and re-appropriate those funds into the DDP community services programs.

*Olmstead* also requires that the State have in place a comprehensive, effectively working plan for placing individuals that actually moves at a reasonable pace. Providing community providers with appropriate financial incentive, or perhaps using institutional funds to build state-operated community homes could accomplish this objective. It would also effectively eliminate all but a very small need for a congregate care center like MDC.

## CONCLUSIONS

1. Montana Code Annotated § 53-20-163 has been a success in that it has placed independent investigators at MDC and has provided far more information than before about the abuse and neglect occurring in MDC.

It is inconceivable that the two administrators at MDC most responsible for critical incident response at MDC, the Superintendent and the Director of Quality Assurance, responded to an incident as critical as a rape with such utter incompetence as to either completely ignore or forget a policy which they themselves wrote. The "I didn't think of it. It never crossed my mind" excuse is not acceptable for the people in charge.

*The "I didn't think of it. It never crossed my mind" excuse is not acceptable for the people in charge.*

It is yet another in a long list of failures of management at MDC. (See list of Immediate Jeopardies and case stories) These failures include the inability to adequately staff the facility, the failure to communicate staff assignments, the failure to properly equip staff with keys to all doors, as well as the failure to provide adequate training, supervision, and

support. These are failures of which DRM is now aware, and can share with policy-makers and the public in an effort to determine the future of MDC.

The pre-screening process was a short-lived but unhelpful development. While it has been discontinued, its use has left some very serious scars and is emblematic of deeper flaws. Examples are: the rape case and the case of the man left for a month who had a herniated disc and then a pulmonary embolism from sitting too long and found by his mother sitting in a chair soaked in urine. In both cases, evidence surfaced that staff did not believe the reports. The result is a system-wide philosophy where staff presume residents are not credible, which is so widespread and customary that in itself is a form of neglect.

2. Substantiated abuse and neglect allegations are the result of culture and practice that tolerate abuse and neglect problems. The problems cannot be fixed with an insufficient labor pool, and results in accepting poorly suited individuals to employ, rationalizing poor employee performance, and downplaying the seriousness of abuse and neglect by addressing serious events with insufficient disciplinary and retraining attempts.

MDC historically cannot hire and retain qualified professional and direct care staff in Boulder, Montana. The immediate jeopardies bear this out over time, and the case stories demonstrate that the problem persists today. The Superintendent does not have a college degree as was required in the job announcement. Client Service Coordinators, Behavioral Health Clinicians, Shift Managers, the Medical Health Service Manager, a Registered Nurse, an Occupational Therapist, a Speech Pathologist, etc., and numerous Direct Care staff positions were all open as November 6, 2014. The Clinical Director left as of January 8, 2015, and the MSOTA certified Sex Offender Therapist position has been vacant for many months. Professional staff vacancies are treatment vacancies. MDC consistently operates with professional staff vacancies. Thus, MDC consistently operates with treatment vacancies. Thus, treatment vacancies are systemic at MDC.

*Unfortunately, the problems at MDC are not new. This history repeats itself from year-to-year, administration-to-administration, and legislature-to-legislature. Despite the platitudes and best intentions, it cannot be done. MDC cannot be fixed; not the congregate care model with the physical plant and staff resource problems in Boulder, Montana. It is no secret that DRM has sought to close MDC - with good reason.*



The lack of staff training, supervision, support, and competent management at MDC perpetuates a system resistant to change or development where even modest past efforts at intervention and whistle blowing have failed.<sup>11</sup> The lack of swift and certain staff consequences for mistreatment, abuse, and neglect of residents leads to the reasonable conclusion by residents and stakeholders that mistreatment, abuse, and neglect is widely tolerated at MDC.

3. MDC faces another challenge in an inefficient and dangerous layout of the facility buildings, the size of its population, the lack of professional staff available in the area, not to mention the repeated legal problems including a likely *Olmstead* challenge. The *Olmstead* problem can be avoided by deferring appropriations to community-based services in either private or state run programs that are not congregate care model facilities and house four or fewer persons.



<sup>11</sup>See *Travis D. Settlement; Libby Sleath v. MDC, et al.*, which resulted in a \$244,000 judgment against MDC and DPHHS.



4. It is not possible to run a safe, effective ICF/ID and an ICF/IID that functions as a “center for excellence” in Boulder, Montana. Unfortunately, the problems at MDC are not new. This history repeats itself from year-to-year, administration-to-administration, and legislature-to-legislature. Despite the platitudes and best intentions, it cannot be done. MDC cannot be fixed; not the congregate care model with the physical plant and staff resource problems in Boulder, Montana. It is no secret that DRM has sought to close MDC - with good reason. That reason - MDC residents are not safe and are not receiving appropriate treatment from qualified staff.

## **RECOMMENDATIONS**

1. Develop a zero tolerance policy for abuse, neglect, or mistreatment of MDC residents to be implemented by June 2015.
2. Close Montana Developmental Center in Boulder, Montana.
3. Identify a shareholder group that shall include family members of MDC residents, providers, DRM, DPHHS, DOJ, MDC employee union representation, and other stakeholders as deemed appropriate by DPHHS to achieve the transition plan objectives.
4. Develop a transition plan that meets the following objectives:
  - Closure of MDC
  - Halts all new admissions into MDC
  - Transfers all residents on the port /referral list as of April 15, 2015, into appropriate community service
  - Identifies the needs of the remaining residents at MDC and propose through a combination of private and state run services the transition of those remaining residents into appropriate community service by the closure date

- Determine if there is a need for secure services for a limited number of residents and how those services can be developed in community settings
  - Create incentives for current MDC staff to remain employed during the transition and closure of MDC
  - All MDC staff be given opportunities for re-training and re-employment at comparable wages and positions in state government
5. Fund community services to obtain the objectives in the transition plan.

# Exhibits



# Montana Code Annotated 2014

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**53-20-163. Abuse of residents prohibited.** (1) Any form of mistreatment, neglect, or abuse of a resident is prohibited.

(2) A residential facility shall publish in each cottage and building and circulate to staff a written policy statement that defines the facility's requirements for reporting and investigating allegations of mistreatment, neglect, or abuse and injuries from an unknown source.

(3) Each allegation of mistreatment, neglect, or abuse and each injury from an unknown source must be reported immediately to the superintendent of the facility and to the department of justice, and the residential facility shall maintain a written record that:

(a) each allegation and each injury from an unknown source has been reported to the department of justice;

(b) each allegation and each injury from an unknown source has been thoroughly investigated and findings stated;

(c) the investigation into the allegation or injury from an unknown source was initiated within 24 hours of the report of the incident; and

(d) the results were reported to the director of the department of public health and human services.

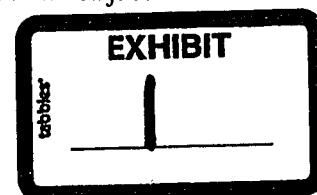
(4) The residential facility shall report the details of each reported allegation, including providing the written record created pursuant to this section, to the mental disabilities board of visitors and the state protection and advocacy program for individuals with developmental disabilities, as authorized by 42 U.S.C. 15043(a)(2), within 5 business days of the incident. The residential facility may not redact any information that is provided pursuant to this subsection. The mental disabilities board of visitors and the state protection and advocacy program shall maintain the confidentiality of any report received under this section to the same extent that the reports are confidential under state and federal laws applicable to the residential facility.

(5) Upon receiving a report of an allegation of mistreatment, neglect, or abuse or of an injury from an unknown source, the department of justice shall conduct a thorough investigation of each allegation or each injury from an unknown source and provide a written report of its investigation and findings to the superintendent of the residential facility within 5 business days of the incident.

(6) The residential facility shall provide the department of justice with access to records and other information necessary to conduct investigations under this section. The department of justice shall maintain the confidentiality of any information received in the course of conducting investigations under this section to the same extent that the information is confidential under state and federal laws applicable to the residential facility.

(7) If a state licensing authority or federal medicaid certification authority issues a statement of deficiency indicating that the residential facility has failed to meet licensing or certification standards due to the thoroughness or timeliness of an investigation conducted under this section, the department of justice shall participate in preparing a plan of correction to restore the residential facility's compliance with licensing or certification standards.

(8) If in the course of conducting an investigation under this section the department of justice develops reasonable cause to believe that a criminal offense has occurred, the department of justice shall refer the matter to the appropriate local law enforcement agency.



**History:** En. 38-1225 by Sec. 25, Ch. 468, L. 1975; R.C.M. 1947, 38-1225; amd. Sec. 23, Ch. 381, L. 1991; amd. Sec. 1, Ch. 27, L. 1993; amd. Sec. 474, Ch. 546, L. 1995; amd. Sec. 1, Ch. 258, L. 2013.

*Provided by Montana Legislative Services*



# MONTANA LEGISLATIVE BRANCH

## Legislative Fiscal Division

Room 110 Capitol Building \* P.O. Box 201711 \* Helena, MT 59620-1711 \* (406) 444-2986 \* FAX (406) 444-3036

Director  
AMY CARLSON

DATE: November 28, 2014  
TO: Members of the Legislative Finance Committee  
FROM: Scot Conrady, Fiscal Analyst  
Barbara Smith, Operations Manager  
RE: MDC, DOJ and resources.

### PURPOSE

After the September meeting of the Legislative Finance Committee (LFC) received additional information regarding the number of recent abuse and neglect allegations at the Montana Development Center (MDC). Data provided from the Department of Public Health and Human Services (DPHHS) was different than data provided by the Department of Justice (DOJ). This report focuses on the respective roles of DPHHS and DOJ in assuring safety at the institutions and corresponding resources.

### New Program - SB 43 (2013)

DOJ's role was established with the passage and approval of SB 43 of the 2013 session. DOJ is now required to investigate, substantiate or not, each referral of suspect abuse, neglect or injury of unknown origin from MDC within five days. This is an investigation of reports and facts, not a criminal investigation. For this new activity DOJ was appropriated of \$194,128 and 1.0 FTE, which was actually a transfer of resources from MDC. Given the diversity of referrals, the amount of information to review, and the tight turnaround, DOJ found it necessary to acquire a 0.5 FTE through the emergency hire process.

As of this writing, for calendar year 2014 DOJ has investigated 55 cases, based on the agency's definition of a case. There is a difference in the quantity of DOJ cases reported versus the amount reported by MDC. The difference is likely a function of reporting methods between the two agencies. For example, one incident, as reported by DOJ, may have multiple findings during one particular incident that are substantiated and reported as such. MDC in contrast, would report and list all of the same findings as DOJ, but would group those and count as one, with a subset of multiple findings.

Another consideration of the investigative process is the fact that clinical history of the client is not a part of the investigations process by DOJ. DOJ findings are based on investigative and corroborative skills. MDC does rely on clinical information in the review process. Clinical history can be important in understanding the client claims in the investigation and substantiation process.

EXHIBIT

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Both DOJ and MDC have committed to standardizing the method of counting incidents in the future to for clarification.

## Resource Challenges

To address workload, DOJ hired an additional 0.5 FTE to keep pace with the work, but that FTE is not requested in the Governor's budget to continue. If the number of referrals does not slow, the program will be inadequately staffed to meet the requirements of SB 43.

MDC has larger resource challenges. The facility has difficulty hiring and maintaining an adequately trained staff. This has led to high turnover, training costs and unmanned shifts. Reasons for this situation may include low wages, a difficult clientele, shift work, the environment of MDC, and the lack of a readily available work force. Consider the situation of direct support staff.

MDC is currently running operations with 111 direct support staff. The optimum level, according to management of the facility would be 135. Due to the spacing and set up of the facility (8 separate buildings located on approximately ¼ mile square area) there is a high requirement for FTE for optimum client supervision. In addition, the workforce is largely unionized and job bidding based on seniority typically results in unfavorable conditions for facility staffing and scheduling. The result of the job bidding process is that, in many occasions, the newest personnel are subject to shift work at the highest secure areas with the most difficult clients during periods where minimal staff and management are present. This has created opportunities with potential unfavorable outcomes.

To achieve optimal staff, an additional 24 FTE are needed at a cost of approximately \$1.9 million. Similar situations exist with behavioral technicians and supervisory staff. MDC is unable to move to optimal staffing without additional budget authority. The facility budget authority was reduced during the last legislative session by approximately \$2.6 million, much of which was rerouted to community providers.

Transition of clients out of MDC to the community has been occurring but it should be noted that some of the client population may not ever be considered appropriate for community living due to the severe intellectual issues, predatory behaviors or violent tendencies that pose imminent risk to the client and others. In the late 1990s MDC received the first criminal commitment, which has since led to a slow change in the population at MDC. Regardless, 14 clients for FY14 and 10 for FY15 year-to-date have been transitioned to the community, a few have returned since then.

## Options

Given the number of challenges facing MDC, the legislature could consider:

- 1) Requesting a study resolution to:
  - a) Define the optimal purpose of MDC
  - b) Determine protocol for oversight of suspect abuse and neglect
  - c) Rebase the budgetary needs of MDC
- 2) Adjust resources as part of the HB 2 process
- 3) Revisit the purpose of SB 43 to clarify intent and agency roles

Updated 12/6/13 Changes highlighted in yellow

FUNDING IS AVAILABLE TO PLACE PEOPLE FROM MDC CONTACTS LIST HOWE AT DDP (444-4182)										
VI	3/8/13	12/1/09	12/1/14	Boulder	Miles City Billings Red Lodge Region 2	Group living and Day	\$236,962	Yes	Jeff Wilson 225-4485	MDC 225-4411
1										
2	3/8/13	8/20/09 Updated 8/17/10 8/22/11 8/9/12	20623	Boulder	Missoula Great Falls Kalispell statewide	Group Day or SE and Supported Living	\$298,141	Yes	Destiny Freiburg 225-4464	MDC 225-4411
3	9/4/13	1/28/11 Update 9/4/13	27435	Boulder	Billings Kalispell Helena Great Falls	Group Day/Group Home	\$149,023	Yes	Destiny Freiburg 225-4464	MDC 225-4411
4	12/05/13	7/28/11 Updated 2/17/13 10/31/13	25735	Boulder	Missoula Anaconda Butte	GH/Day or SL NOT COMMITTED	\$174,562	Yes	Destiny Freiburg 225-4464	MDC 225-4411
5	9/4/13	2/10/12 Update 9/4/13	585	Boulder	Great Falls	Group Day / Supported Living	\$125,460	Yes	Destiny Freiburg 225-4464	MDC 225-4411
6	12/05/13	2/17/12 Update 9/4/13 10/21/13	15791	Boulder	Helena Missoula	GH/Day or SL/SE NOT COMMITTED	\$175,825	Yes	Judy Uhlrich 225-4476	MDC 225-4411
7	12/05/13	4/2/12 4/9/13	22378	Boulder	Browning Butte Missoula Others	GH/Day	\$143,448	Yes	Destiny Freiburg 225-4464	MDC 225-4411
8	9/4/13	5/16/12 Update 9/4/13 10/25/13	7125	Boulder	Billings Helena Great Falls	GH/Day NOT COMMITTED	\$125,993	Yes	Destiny Freiburg 225-4464	MDC 225-4411

EXHIBIT

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9	11/29/13	10/31/12 11/25/13	24068	Boulder	Missoula Helena Plentywood	GH/Day	\$111,563	Yes	Judy Uhrich 225-4476	MDC 225-4411
10	3/1/13	11/2/12	6600	Boulder	Red Lodge Billings Lewistown	GH/Day	\$100,771	Yes	Judy Uhrich 225-4476	MDC 225-4411
11	3/8/13	12/14/12	3045	Helena	Helena	GH/Day or SL/Day	\$138,160	Yes	Jeff Wilson 225-4485	MDC 225-4411
12	12/5/13	1/24/13 12/5/13	16529	Boulder	Great Falls	SL/Day	\$107,153	Yes	Judy Uhrich 225-4476 Jeff Wilson 225-4485	MDC 225-4411
13	4/19/13	4/11/13	27681	Boulder	Dillon Red Lodge Great Falls Statewide	GH/Day or any placement	\$83,311 MONA	Yes	Jeff Wilson 225-4485	MDC 225-4411
14	9/4/13	9/4/13	8630	Boulder	Anaconda Billings Missoula Helena	GH/Day	\$102,496	Yes	Judy Uhrich 225-4476	MDC 225-4411
15	9/4/13	9/4/13	123923	Boulder	Butte Billings Helena	CSL/CE and /or Day	\$88,448	Yes	Jeff Wilson 225-4485	MDC 225-4411
16	9/4/13	9/4/13	35833	Boulder	Great Falls Butte Bozeman	GH/Day or CSL	\$176,099	Yes	Judy Uhrich 225-4476	MDC 225-4411
17	9/4/13	9/4/13	119742	Boulder	Miles City Malta Plentywood Possibly Billings	GH/Day or CSL/SE	\$112,466	Yes	Judy Uhrich 225-4476	MDC 225-4411
18	9/4/13	9/4/13	3516	Boulder	Helena Other cities considered	GH/Day possibly SL	\$142,818	Yes	Judy Uhrich 225-4476	MDC 225-4411
19	9/4/13	9/4/13	14774	Boulder	Helena Great Falls	SL/Day or SE	\$112,466	Yes	Judy Uhrich 225-4476	MDC 225-4411
20	9/27/13	9/27/13	444959	Boulder	Missoula Helena Butte	Group Home/Day	\$83,642	Yes	Judy Uhrich 225-4476	MDC 225-4411
21	9/27/13	9/27/13	16319	Boulder	Helena	Group Home/Day	\$100,000	Yes	Judy Uhrich 225-4476	MDC 225-4411



22	10/25/13	10/25/13	16180	Boulder	Red Lodge Butte Helena Great Falls Missoula	Group Home/Day	\$118,166	Yes	Destiny Freiburg 225-4464	MDC 225-4411
23	10/25/13	10/25/13	12175	Boulder	Missoula Helena Butte	Group Home/Day	\$134,606	Yes	Destiny Freiburg 225-4464	MDC 225-4411
24	10/25/13	10/25/13	21462	Boulder	Great Falls Will consider other areas	Group Home/Day	\$134,606	Yes	Destiny Freiburg 225-4464	MDC 225-4411
25	10/25/13	10/25/13	152343	Boulder	Wants to live near Antelope	Group Home/Day or Congregate Supported Living/Day	\$103,383	Yes	Destiny Freiburg 225-4464	MDC 225-4411
26	10/25/13	10/25/13	14196	Boulder	Billings Helena Missoula Others	Group Home/Day	\$148,395	Yes	Destiny Freiburg 225-4464	MDC 225-4411
27	11/15/13	11/15/13	21460	Boulder	Helena Butte Great Falls	Group Home Day NOT COMMITTED	\$136,313	Yes	Destiny Freiburg 225-4464	MDC 225-4411
28	11/22/13	11/20/13	11525	Boulder	Helena Havre Great Falls	Group Home/Day	\$148,828	Yes	Judy Ulrich 225-4476	MDC 225-4411

# MDC PORT LIST

1-16-15

Date of Notice	AWACS #	Facility	Preferred Cities	Preferred Services	Estimated ICP	Contact Person	MDC Client Services Coordinator	MDC phone	comments
7/28/2011	25735 (not committed)	MDC	Missoula Helena Butte Anaconda	GH/Day	\$241,495	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
9/4/2013	149742	MDC	Miles City Malta Billings Plentywood	GH/Day or SL/SE	\$130,550	Leslie Howe 444-4182	Judy Uhrich 225-4476	MDC 225-4411	possible mental health placement?
7/23/2014	22863	MDC	Helena Bozeman Butte	GH/Day	\$139,500	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
8/8/2014	152343	MDC	Antelope and will consider other cities	GH/Day	\$116,999	Leslie Howe 444-4182	Judy Uhrich 225-4476	MDC 225-4411	
1/24/2013	16529	MDC	Missoula	SL/SE	\$160,469	Leslie Howe 444-4182	Judy Uhrich 225-4476	MDC 225-4411	pending mental health placement in Missoula
4/12/2012	22378 (not committed)	MDC	Browning Butte Missoula other cities	GH/Day	\$145,395	Leslie Howe 444-4182	Mark Mihailovich 225-4485	MDC 225-4411	
11/15/2013	21460 (not committed)	MDC	Helena Great Falls Butte	GH/Day	\$134,596	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
1/28/2011	7435	MDC	Billings Missoula Helena Great Falls other cities	GH/Day	\$161,854	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	

EXHIBIT

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**MDC PORT LIST  
1-16-15**

Date of Notice	AWACS #	Facility	Preferred Cities	Preferred Services	Estimated ICP	Contact Person	Client Services Coordinator	Provider Phone	comments
10/25/2013	16180	MDC	Red Lodge Butte Helena Great Falls Missoula	GH/Day	\$134,596	Leslie Howe 444-4182	Mark Mihailovich 225-4485	MDC 225-4411	
	22967 (not committed)		Kalispell Great Falls Helena	GH/Day	\$118,867	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	
10/25/2013	14196	MDC	Billings Helena Missoula statewide	GH/day	\$151,981	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
10/25/2013	21462	MDC	Great Falls other cities considered	GH/Day	\$134,596	Leslie Howe 444-4182	Mark Mihailovich 225-4485	MDC 225-4411	
10/25/2013	12175	MDC	Missoula Helena Butte	GH/Day	\$134,596	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
8/20/2009	20623	MDC	Missoula Great Falls Kalispell Statewide	SL/SE or day	\$308,210	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
8/14/2014	2972 (not committed)	MDC	Missoula Kalispell Polson other cities	Group or individual residential/D ay	\$94,568	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	
11/2/2012	6600	MDC	Billings RedLodge Lewistown	GH/Day	\$156,683	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	



**1-16-15**

Date of Notice	AWACS #	Facility	Preferred Cities	Preferred Services	Estimated ICP	Contact Person	Client Services Coordinator	Provider Phone	comments
9/4/2013	123923	MDC	Helena Butte Billings statewide	congregate SL/Day	\$141,149	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
9/16/2014	27845	MDC	statewide	GH/Day or CSL/Day	\$116,461- 125,180	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	will consider any city
2/9/2012	585	MDC	Great Falls possibly other cities considered	SL/Day	\$125,358	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	
11/27/2007	12174	MDC	Missoula and cities near Missoula	GH/Day	\$252,561	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	
11/22/2013	11525	MDC	Great Falls Helena Havre	GH/Day or congregate living/day	\$155,442	Leslie Howe 444-4182	Judy Uhlrich 225-4476	MDC 225-4411	
9/4/2013	14774	MDC	Helena Great Falls	SL/Day	\$143,707	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
8/1/2014	7517	MDC	in or near Helena	GH/Day	\$133,252	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	
11/19/2014	279282 (not committed)*	MDC	Helena	GH/Day	EICP still needed	Leslie Howe 444-4182	Layla Coffman 225-4478	MDC 225-4411	in process but is not Medicaid eligible at this time

# MDC PORT LIST

1-16-15

Date of Notice	AWACS #	Facility	Preferred Cities	Preferred Services	Estimated ICP	Contact Person	MSH Social Worker	Provider Phone	comments
3/28/2013	12862	MSH	Missoula	GH/Day or SL/Day	\$237,091	Leslie Howe 444-4182	Tabitha Knadler 693-7476	MDC 225-4411	currently in Warm Springs

## MESSAGES:

MDC TRANSITION STIPENDS ARE AVAILABLE FOR PROVIDERS TO SERVE PEOPLE REFERRED FROM MDC. A template of the contract is attached for review. Here is the Title 20 link: <http://www.ssa.gov/OP-Home/ssact/title20/2000.htm> (You will need to copy and paste this to your browser.)

Stipend amounts are as follows: \$20,000 GRANTS FOR COST PLANS UNDER \$150,000 AND \$30,000 GRANTS FOR COST PLANS OVER \$150,000. This grant includes the people included in the list above that are eligible for placement into DD services from the Montana State Hospital.

THE SHARE POINT SITE HAS REFERRALS, PROPOSAL FORMS, AND STIPEND APPLICATIONS AND CONTRACT TEMPLATE. An announcement section was added to show changes. Here is the link to the access form to use Share Point: <http://www.dphhs.mt.gov/tsc/securityaccessforms.shtml>

The completed OM-300 B form is submitted to Leslie Howe by paper copy or electronically.

PLEASE CONTACT LESLIE HOWE AT DDP (444-4182 or [lhowe@mt.gov](mailto:lhowe@mt.gov)) TO REQUEST ADDITIONAL REFERRAL INFORMATION AND INFORMATION ON ACCESSING SHARE POINT. PROPOSALS MUST BE SUBMITTED TO LESLIE.

35265 removed from port list. Proposal was accepted. Transition planning started. 16972 was removed from the port list - was

Time of Initial Report:						
Date of Initial Report:						
Steps / Actions	Time Frame	Responsibility	Completed ✓	Completed Date	Placed in Investigative File ✓	Form
1. Report immediately to the Boulder Police Department.	immediately	Client Protection Specialist, Registered Nurse, or Human Services Specialist				
2. Direct nursing staff to transport or accompany the alleged victim by ambulance to the Saint Peter's Hospital Emergency Room in Helena for medical examination specific to the type of sexual abuse allegation.						
3. Notify the Superintendent, Clinical Director, Medical Director, Psychiatrist, and Nursing Director in person or by telephone.						
4. The Clinical Director notifies the guardian.						
5. Ensure that the alleged victim does not bathe, wash hands, or change clothes.						
6. Do not touch or move any item that may have been used as a weapon; wait for law enforcement to arrive.						
7. Secure the incident scene and do not disturb any part of the scene or any potential evidence in the area.						
8. If evidence must be disturbed (example: removal of broken glass for client safety), follow these guidelines: A. Porous Materials (clothing, bedding, gloves): Store in porous containers such as paper bags. B. Non-porous Materials (plastics, metal, glass): Store in non-porous containers such as plastic bags.						

EXHIBIT

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ATTORNEY GENERAL  
STATE OF MONTANA

Tim Fox  
Attorney General



Department of Justice  
215 North Sanders  
PO Box 201401  
Helena, MT 59620-1401

MEMORANDUM

TO: DANA TOOLE, DCI  
CC: BRYAN LOCKERBY, DCI  
FROM: J. STUART SEGREST *JSS*  
RE: MDC Abuse Report Timing  
DATE: October 30, 2014

INTRODUCTION

Bureau Chief Dana Toole requests a review of the requirement under Mont. Code Ann. § 53-20-163(3) that "[e]ach allegation of mistreatment, neglect, or abuse and each injury from an unknown source must be reported immediately to the superintendent of the facility and to the department of justice . . . ." DOJ is not receiving the allegations of abuse immediately. Instead MDC policy directs that the MDC event management committee meet first, within 24 hours of the Superintendent receiving a report of abuse, to decide whether or not the report warrants further investigation. If the committee decides investigation is warranted, the report is forwarded to DOJ to conduct the investigation, but if the committee decides investigation is not warranted the report is not forwarded to DOJ. Further, a review of reporting time and dates from May 1, 2014 to October 1, 2014 indicates that in some instances it took longer than 24 hours for MDC to forward reports to DOJ. Bureau Chief Toole questions whether this screening process is permitted under the statute, or if each allegation should instead simultaneously be reported to DOJ at the time the allegation is first reported to the Superintendent.

SUMMARY

Montana Code Annotated § 53-20-163(3) requires that each allegation be reported immediately to DOJ at the time it is first reported to the Superintendent, and does not

permit MDC a 24-hour window to review and screen the report before it is forwarded to DOJ.

### ANALYSIS

In interpreting the meaning of a statute, the first step is to determine whether the intent of the statute can be determined from the statute's plain language. *State v. Johnson*, 2012 MT 101, ¶ 19, 365 Mont. 56, 277 P.3d 1232. If the intent is clear from the statutory language, no further inquiry is necessary. *Id.* A court will not add language to a statute, nor will it ignore the statute's express language. *Id.*, ¶ 20.

Montana Code Annotated § 53-20-163(3) states that "each allegation . . . must be reported immediately to the superintendent of the facility and to the department of justice . . . ." (Emphasis added). "Immediately" means "without any delay<sup>1</sup>," and there is no indication that this command applies only to providing notice of the allegation to the Superintendent. On the contrary, the statute expressly states that report must be immediately provided to the Superintendent "and" DOJ. Thus the express language requires that an abuse allegation be reported as soon as it is made, and further contemplates that the abuse will be reported contemporaneously to both DOJ and the Superintendent.

Despite this express command, MDC's legal counsel has stated in an email that she interprets § 53-20-163(3)(c)'s requirement that "the investigation [be] initiated within 24 hours of the report of the incident" as including MDC's "preliminary investigation." Though not entirely clear, it appears she is arguing that because (3)(c) contemplates the investigation will begin within 24 hours, MDC has 24 hours to provide notice to DOJ after an allegations is reported to the Superintendent.

While MDC's position is reasonable from a practical standpoint, I do not agree with this interpretation because it ignores the express language of the statute and adds language that is not included. First, as discussed above, a 24-hour preliminary investigation is not allowed for or contemplated by the first sentence to § 53-20-163(3), which requires an allegation be reported without delay to the Superintendent and DOJ. Waiting 24 hours after the incident is reported to the Superintendent to report the matter to DOJ, if it is reported at all, simply is not allowed or contemplated by this express provision.

Second, even if this first sentence were not as clear as it is, the "investigation" referenced in 3(c), which must be "initiated within 24 hours," applies to DOJ, not MDC, because the statute charges DOJ with conducting the investigation. See §§ 53-20-163(5), (8) ("the department of justice shall conduct a thorough investigation of each allegation"). Indeed,

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<sup>1</sup> Merriam-Webster 2014.